PRINTED: 10/13/2011

	R MEDICARE & MEDIC					OMB NO. 0938-0391	
		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE C A. BUILDING B. WING	00	09/2	(X3) DATE SURVEY COMPLETED 09/26/2011	
	NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for the Investigation of Complaint IN00097362. Complaint IN00097362 - Substantiated. Federal/state deficiencies related to the allegation are cited at F225 and F226. Survey dates: September 23 & 26, 2011 Facility number: 000029 Provider number: 155072 AIM number: 100275200 Survey team: Joyce Hofmann, RN	2002 A	ADDRESS, CITY, STATE, ZIP CODE ALBANY ST H GROVE, IN46107				
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TAG DEFICIENCY		ON SHOULD BE COM HE APPROPRIATE		
F0000	This visit was for Complaint IN00 Complaint IN00 Federal/state de allegation are cillustrated Survey dates: Survey dates: Survey dates: Survey dates: AIM number: 1	or the Investigation of 2097362. 2097362 - Substantiated. ficiencies related to the ted at F225 and F226. September 23 & 26, 2011 2: 000029 2r: 155072 2:00275200 2: oyce Hofmann, RN	F0000			DATE	
	Census payor ty Medicare: 21 Medicaid: 75 Other: 41	rpe:					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

findings cited in accordance with 410 IAC

These deficiencies also reflect state

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Total: 137

Sample: 3

16.2.

Event ID:

WLEL11 Facility ID:

000029

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155072	B. WIN			09/26/2	011
	PROVIDER OR SUPPLIER GROVE MEADOWS		1	STREET A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST GROVE, IN46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID BROWINERS BLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	_	DATE
F0225 SS=D	Williams, RN The facility must no have been found of or mistreating resident have had a finding nurse aide registry mistreatment of resident of their property; and has of actions by a service as a nurse the State nurse aide authorities. The facility must eviolations involving abuse, including in and misappropriation reported immediate the facility and to with State law through (including to the Stagency). The facility must halleged violations and must prevent the investigation is the investigation is state survey and of working days of the violation is verified action must be take Based on observations.	nvestigations must be ministrator or his designated to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective	F0	225	F 225 Investigate/Report Allegations/Individuals This		10/05/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155072	B. WIN			09/26/20	011
NAME OF	PROVIDER OR SUPPLIEF	}			ADDRESS, CITY, STATE, ZIP CODE		
		_		1	BANY ST		
BEECH	GROVE MEADOWS	5		BEECH	GROVE, IN46107		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	tions of abuse were			provider ensures that all alle		
	reported immediately to the Administrator				violations involving mistreatn neglect, or abuse, including	nent,	
	of the facility, for	or 1 of 3 residents			injuries of unknown origin are	e	
	reviewed for alle	egations of abuse in a			reported immediately to the		
	sample of 3. [Re	sident #B]			administrator of the facility a	nd to	
	'	-			other officials in accordance		
	Findings include	••			state law through established		
	i mamgs merade	·•			procedures. What corrective		
	 Tank a area i a a a a a a i i i la ki	ne Administrator on			action(s) will be accomplish for those residents found to		
					have been affected by the		
		p.m. indicated no			deficient practice.		
	1	use had been reported to			The aide in question was		
	him in the last 24	4 hours.			suspended pending investiga	ation	
					to ensure the safety of reside	ents.	
	Interview with C	CNA #1 on 09/23/11 at			The employee who did not re	eport	
	3:02 p.m. indica	ted he was afraid			the allegation of abuse was		
	_	eing sexually abused by			suspended pending investigation		
		licated this was not the			for failure to report alleged a The employee who did not re		
		f abuse with CNA #2.			the allegation of abuse was	Sport	
	1	s had said this was the			eventually terminated for not		
		A #2 could work on.			following our reporting policy	'.	
	1				A vaginal assessment and		
	_	ed the first allegation was			interview of the resident by D		
		got upset when CNA #2			and Surveyor completed. No injuries noted. Resident den		
		nt to rub his genital area,			pain or discomfort.		
		llegation was a different			Family and Physician notified	d of	
		eged the same and made			the allegation and that the fa	cility	
		uncomfortable due to his			was investigating.		
	sexual advances	. CNA #1 did not indicate			How will you identify other		
	when these two	incidents occurred. CNA			residents having the potent to be affected by the same	ııaı	
	#1 alleged CNA	#3 had told him about			deficient practice and what		
	bruising when R	N #1 tried to straight cath			corrective action will be take		
		a urine specimen, and			Residents that reside in the		
		isting the RN at the time.			facility are at risk for the alleg	ged	
		ed he did not have any			deficient practice.		
		sident #B that evening or			Customer care reps make da	aliy	
	1 John Willi Mes	Turne in the control of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155072 09/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2002 ALBANY ST **BEECH GROVE MEADOWS** BEECH GROVE, IN46107 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE with CNA #2, even though they worked rounds to each resident to inquire about how things are and if they the same shift the evening of the alleged are comfortable with care they incident. CNA #1 denied having any disagreements or animosities going on What measures will be put into between himself and CNA #2. CNA #1 place or systemic changes you will make to ensure that the explained CNA #2 was the aide taking deficient practice does not care of Resident #B and numerous other recur. · Staff was inserviced on women on the hall. CNA #1 explained he 9/23/11-9/26/11 by DNS and Staff did not go to the Administrator or follow **Development Coordinator** regarding abuse policies, with the chain of command, because he did not emphasis placed on reporting any think the administrative staff would do allegation of abuse to the DNS anything about the situation. and Executive Director immediately. · In addition, Interview with CNA #2 on 09/23/11 at stressed to staff that it is their obligation to follow reporting 3:30 p.m. indicated he had been a CNA procedures and that failure to do for 2 1/2 years. CNA #2 indicated he so would result in termination as worked with Resident #B and also worked well as possible loss of their with CNA #1. CNA #2 indicated he did license and ability to work in the Healthcare industry. not know CNA #1 other than through Customer care reps make daily work and did not know him well. The rounds to each resident to inquire employee record form indicated CNA #2 about how things are and if they worked at the facility since 04/10/10 and are comfortable with care they receive if anything is identified CNA #1 had worked at the facility since during rounds a thorough 08/10/11. investigation of the allegation will be conducted by the ED or Interview with the Administrator and designee. How the corrective action(s) will Director of Nursing [DON] on 09/26/11 at be monitored to ensure the 2 p.m. indicated there were two other deficient practice will not recur, incidents with CNA #2 which both i.e., what quality assurance program will be put into place. happened on 07/15/11 and both CQI tool "Abuse Prohibition and investigated. The first incident was with a Investigation" will be completed male resident who was end stage randomly on all shifts weekly Parkinson's with lower extremity times 4, monthly times 2, and contractures and end stage dementia. The quarterly x 2. If deficiencies

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	155072	A. BUI	LDING	00	09/26/2	
		133072	B. WIN			09/20/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE LBANY ST		
BEECH	GROVE MEADOWS			1	GROVE, IN46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	resident had dry	skin in his scrotal area			noted, an action plan will be		
	and staff were ap	plying lotion and			developed and implemented		
	preventative crea	ms during incontinence			DNS or designee is responsi for monitoring compliance. A		
	1 -	nt needed two staff to			findings will be brought to the		
	provide care due	to the contractures and			team on a monthly basis.		
	while providing	care, the resident thought					
		inappropriately. The					
	resident's roomm	ate and spouse were in					
	the room and did	not voice any concern or					
	complaint. A hea	ad to toe assessment was					
	completed with r	no injury. Staff involved					
	were immediately	y removed from the care					
	of the resident.	The Social Service					
	Director met with	h the resident and found					
	no distress or rec	ollection of concern					
	upon interview th	ne same evening.					
	Communication	techniques were					
	explained to the	staff involved.					
	Explanation prov	rided that all					
	communication s	should be in language,					
	format, volume e	easily understood by the					
	resident being ca	red for.					
		ent involved a female					
		s confused and had					
	delirium. The re	sident was noted to have					
	an abscess or boi	1 to her groin area. The					
	resident alleged t	the aides made comments					
	_	tting to her, but no					
		ntact. The staff were					
	immediately rem	oved from her care. The					
	two aides involve	ed had been employed for					
	2 years at the fac	ility and had no resident					
	complaints. Soci	ial Service Director					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155072	B. WIN			09/26/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	ę.		2002 AI	LBANY ST		
	GROVE MEADOWS				GROVE, IN46107		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	+	TAG	BLI ICILIACI)		DATE
	1	resident immediately and					
	"	nd inconsistencies in					
	1 ~	ls. Social Services met					
		and found no distress or					
		oncern upon interview the					
	same evening.						
	Interview with R	RN #1 on 09/23/11 at 2:14					
	p.m. indicated sl	ne did straight cath					
	1 ^	an urine specimen on					
	1	/11 and at first could not					
	1 -	opening for the catheter.					
	1	she went and got a					
		and laid the resident on					
		able to get the urine					
	1	indicated right where you					
	1 -	theter was a little purple					
	1 -	if the resident was					
	1	nat, as it was harder than					
		RN #1 indicated there					
	1	ears, no bleeding, but just					
	1	nal to find the right place.					
		she had CNA #3 in the					
	1	uring the urine specimen					
		‡1 indicated she did not					
	report this to any	one.					
	Interview with C	CNA #3 on 09/23/11 at					
	2:55 p.m. indica	ted she worked last night					
	1 -	oom with RN #1 to collect					
		en. CNA #3 indicated					
	1 -	area being bruised,					
	1	CNA #3 indicated the					
	1						
	nurse could not	get the urine sample the					

000029

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 09/26/2	ETED	
	PROVIDER OR SUPPLIEF		,	2002 AL	DDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN46107	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	the resident on hindicated she toll hand and if it hu hand. CNA #3 is hand. CNA #3 is nurse discussed a private area and to the Director of unit manager. Coanyone about the During observate Resident #B was and nothing unuresident at this till her down there. Review of Resident on 09/23/11 at 2 most recent sign Data Set [MDS] 09/23/11, the resident cognitively imparts making-skills and Telephone Order an order for an usensitivity due to confusion. Nurse at 0130 [1:30 a.r. [urinalysis] collection.	con on 09/23/11 at 2 p.m., examined by the DON sual was found. The me denied anyone hurting tent #B's clinical record 150 p.m. indicated on the ifficant change Minimum assessment dated ident was severely tired with daily decision d confused. A Physician dated 09/21/11 indicated rinalysis with culture and or increased agitation and e's notes dated 09/23/11 indicated, "U/A acted and sent"					

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Event ID: WLEL11 Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155072	B. WING		09/26/2011
	PROVIDER OR SUPPLIER		2002 AI	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN46107	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0226 SS=D	reviewed on 09/2 " All abuse allereported to the Elimmediately, and representative (sp. within 24 hours of report will result to and including termination" This federal defect Complaint IN000 3.1-28(c) The facility must dwritten policies and mistreatment, negrand misappropriately Based on observative record review, the implement their puthat prohibit allegations not be reported to the Aresidents reviewed of 3. [Resident # Findings include Interview with the complex properties of the Aresidents reviewed	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. ation, interview, and the facility failed to policy and procedures ged abuse, related to eing immediately dministrator, for 1 of 3 ed for abuse in a sample failure to indicate the facility failed to policy and procedures ged abuse, related to eing immediately dministrator, for 1 of 3 ed for abuse in a sample failure to indicate the failure and the failure a	F0226	F 226 Develop/Implement Abuse/Neglect, etc Policies This provider ensures that w policies will be implemented developed that prohibit mistreatment, neglect, and a of residents and misappropri of resident property. What corrective action will be accomplished for those residents found have been affected by deficient practice.	rritten and abuse iation (s) or to
				The aide in question was	

l ·		(X2) M	ULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155072	B. WIN	G		09/26/2011
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE	
				1	BANY ST	
BEECH	GROVE MEADOWS	3		BEECH	GROVE, IN46107	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG	1	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	allegations of abuse had been reported to				suspended pending investigate to ensure the safety of reside	
	him in the last 24	4 hours.			The employee who did not re	
					the allegation of abuse was	F - 17
		CNA #1 on 09/23/11 at			suspended pending investiga	
	3:02 p.m. indicat	ted he was afraid			for failure to report alleged al	
	residents were be	eing sexually abused by			The employee who did not re the allegation of abuse was	eport
	CNA #2, and ind	licated this was not the			eventually terminated for not	
	first allegation of	f abuse with CNA #2.			following our reporting policy	
	Other co-worker	s had said this was the			A vaginal assessment and	
	last hallway CNA	A #2 could work on.			interview of the resident by D	
	1	ed the first allegation was			and Surveyor completed. No injuries noted. Resident den	
	1	got upset when CNA #2			pain or discomfort.	leu
	1	nt to rub his genital area,			Family and Physician notified	d of
		llegation was a different			the allegation and that the fa	
		eged the same and made			was investigating.	
		uncomfortable due to his			How will you identify other	ial
		CNA #1 did not indicate			residents having the potent to be affected by the same	ııdı
		incidents occurred. CNA			deficient practice and what	
		#3 had told him about			corrective action will be tak	
	1	N #1 tried to straight cath				
	1	a urine specimen, and			Residents that reside in the	. a d
	I	isting the RN at the time.			facility are at risk for the alleg deficient practice.	geu
		•			Customer care reps make da	aily
		ed he did not have any			rounds to each resident to in	
		ident #B that evening or			about how things are and if the	-
	1	ven though they worked			are comfortable with care the	с у
		e evening of the alleged			receive. What measures will be	
		to denied having any				mio
	1 ~	r animosities going on			put into place or system	
		and CNA #2. CNA #1			changes you will make ensure that the deficien	
	explained CNA #2 was the aide taking					
	care of Resident #B and numerous other				practice does not recu	f.
		all. CNA #1 explained he			 Staff was inservice 	ed
	did not go to the Administrator or follow				on 9/23/11-9/26/11 by D	
	the chain of com	mand, because he did not			On arzar in-arzar in by D	140
FORM CMS-	2567(02-99) Previous Version	ons Obsolete Event ID:	WLEL11	Facility I	D: 000029 If continuation sl	neet Page 9 of 14

l i		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155072	B. WIN	G		09/26/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
				1	BANY ST		
BEECH	GROVE MEADOWS	i		BEECH	GROVE, IN46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	 	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		strative staff would do			and Staff Development		
	anything about the situation.				Coordinator regarding		
					abuse policies, with		
		NA #2 on 09/23/11 at			emphasis placed on	_	
	1 ^	ed he had been a CNA			reporting any allegation	of	
		CNA #2 indicated he			abuse to the DNS and		
	worked with Res	ident #B and also worked			Executive Director		
	with CNA #1. C	NA #2 indicated he did			immediately.		
	not know CNA#	1 other than through			 In addition, stress 	sed	
	work and did not	know him well. The			to staff that it is their		
	employee record	form indicated CNA #2			obligation to follow repo	•	
	worked at the fac	eility since 04/10/10 and			procedures and that fail	ure	
		ked at the facility since			to do so would result in		
	08/10/11.	J			termination as well as		
					possible loss of their lic		
	 Interview with th	e Administrator and			and ability to work in the	9	
		ing [DON] on 09/26/11 at			Healthcare industry.		
		there were two other			Customer care reps make d		
		NA #2 which both			rounds to each resident to in about how things are and it	•	
	happened on 07/2				are comfortable with care the		
	1 **				receive if anything is identified		
	ı	e first incident was with a			during rounds a thorough		
	male resident wh	•			investigation of the allegation	n will	
	Parkinson's with	•			be conducted by the ED or		
		end stage dementia. The			designee. All investigations of allegations	ns of	
		skin in his scrotal area			abuse, neglect or		
	_	plying lotion and			misappropriation of property		
	_	ms during incontinence			be reported within 24 hours	to	
		nt needed two staff to			ISDH.		
	l ^	to the contractures and			All investigations will be thoroughly investigated by		
	while providing	care, the resident thought			ED/DNS within 5 days of the	:	
	they touched him inappropriately. The			incident.			
	resident's roomm	ate and spouse were in					
	the room and did	not voice any concern or			How the corrective action(s)	will	
		ad to toe assessment was			be monitored to ensure the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155072	- 1	LDING	00	09/26/2	
		100072	B. WIN		DDDEGG CITY CTATE ZIR CODE	03/20/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE LBANY ST		
BEECH (GROVE MEADOWS	3		1	GROVE, IN46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG		no injury. Staff involved	-	IAG	deficient practice will not rec	ır	DATE
	1				i.e., what quality assurance	u.,	
	were immediately removed from the care of the resident. The Social Service				program will be put into place.		
		h the resident and found			CQI tool "Abuse Prohibition and		
		ollection of concern			Investigation" will be complete		
	upon interview th				randomly on all shifts weekly		
	Communication	_			times 4, monthly times 2, and quarterly x 2. If deficiencies	d	
	explained to the	-			noted, an action plan will be		
	Explanation prov				developed and implemented		
	communication s	should be in language,			DNS or designee is responsi		
	format, volume e	easily understood by the			for monitoring compliance. A findings will be brought to the		
	resident being ca	red for.			team on a monthly basis.	<i>.</i>	
	The second incideresident who was delirium. The rean abscess or boing resident alleged to which were upsed in immediately removed two aides involved 2 years at the fact complaints. Social interviewed the rean oted changes and speech and details with the resident recollection of complaints.	dent involved a female is confused and had sident was noted to have I to her groin area. The is the aides made comments itting to her, but no intact. The staff were coved from her care. The ed had been employed for illity and had no resident ital Service Director resident immediately and inconsistencies in its. Social Services met and found no distress or oncern upon interview the			team on a montniy basis.		
	same evening.	N #1 on 09/23/11 at 2:14					
		the did straight cath					
	_	an urine specimen on					
	1 101 01 01 01 01 01 01 01 01 01 01 01 0	opermien on					

I '		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155072	B. WIN			09/26/2	011
NAME OF	PROVIDER OR SUPPLIER	2		1	ADDRESS, CITY, STATE, ZIP CODE		
DEECH				1	BANY ST		
	GROVE MEADOWS			<u> </u>	GROVE, IN46107		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG	+	,	+	IAG	Dia teliate i j		DATE
	night shift 09/22/11 and at first could not find the correct opening for the catheter						
	find the correct opening for the catheter.						
	1	she went and got a					
		and laid the resident on					
	1	able to get the urine					
	1 -	indicated right where you					
	~	theter was a little purple					
		if the resident was					
	1	nat, as it was harder than					
		RN #1 indicated there					
	1	ears, no bleeding, but just					
		nal to find the right place.					
		she had CNA #3 in the					
	1	uring the urine specimen					
	collection. RN #	‡1 indicated she did not					
	report this to any	one.					
	Interview with C	CNA #3 on 09/23/11 at					
	2:55 p.m. indica	ted she worked last night					
	and was in the ro	oom with RN #1 to collect					
	the urine specim	en. CNA #3 indicated					
	she noticed the a	rea being bruised,					
	colored purple.	CNA #3 indicated the					
	nurse could not	get the urine sample the					
	first try and had	to try again and turned					
	the resident on h	er side. CNA #3					
	indicated she tol	d the resident to hold her					
	hand and if it hu	rt she could squeeze her					
	hand. CNA #3 i	ndicated she squeezed her					
	1	ndicated she and the					
	nurse discussed	the color of the resident's					
	private area and	the nurse was to report it					
	1 ~	f Nursing [DON] and the					
	1	NA #3 denied telling					

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155072	B. WIN			09/26/2011	
NAME OF F	PROVIDER OR SUPPLIER		'	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	LBANY ST		
BEECH (GROVE MEADOWS	3		BEECH	I GROVE, IN46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		ION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)	DATE	
	anyone about the	situation.					
	D	00/22/11 -4 2					
	~	on on 09/23/11 at 2 p.m.,					
		examined by the DON					
		sual was found. The					
		me denied anyone hurting					
	her down there.						
	Davious of David	ent #B's clinical record					
		50 p.m. indicated on the					
		ficant change Minimum					
		assessment dated					
	I	ident was severely					
	" '	ired with daily decision					
	_	d confused. A Physician					
	1 ^	dated 09/21/11 indicated					
		rinalysis with culture and					
	1	increased agitation and					
		e's notes dated 09/23/11					
	_	n.] indicated, "U/A					
	[urinalysis] colle	cted and sent"					
	TI C 11'. 1 41	D 1.11.141					
	The facility's Ab	•					
	1 2	nvestigation Policy and					
		February 2010 was					
		26/11 at 11 a.m. indicated,					
		egations/abuse must be					
	_	xecutive Director					
	immediately, and						
	^ `	ponsor, responsible party)					
		of the report. Failure to					
	report will result in disciplinary action, up						
	to and including	immediate					
	termination"						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155072	A. BUILDING 00		- 09/26/2011	
		100072	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/20/2011	
NAME OF PROVIDER OR SUPPLIER 2002 ALBANY ST						
BEECH GROVE MEADOWS BEECH GROVE, IN46107						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	· ·	LSC IDENTIFYING INFORMATION)	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE	
	This federal defice Complaint IN000	ciency is related to 097362.				
	3.1-28(a)					